Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PINE CREEK MEDICAL CENTER
9032 HARRY HINES BLVD
DALLAS TX 75235

Respondent Name
FIDELITY & GUARANTY INSURANCE CO

Carrier's Austin Representative Box
#19

MFDR Tracking Number
M4-10-0221-01

MFDR Date Received
SEPTEMBER 11, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Bill was paid a total of $16,076.68 which was under paid per the implants…I am requesting for assistance in resolving this matter and having this claim be paid in accordance with the DRG 470 & Implants…"

Amount in Dispute: $14,429.07

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated October 14, 2009: "It has been re review & determined no additional are allowed."

Response Submitted by: Gallagher Bassett, 6504 International Parkway, Suite 2100, Plano, TX 75093

Respondent's Supplemental Position Summary Dated April 9, 2010: "Carrier has previously responded to this dispute. DWC then requested additional documentation in the form of the contract between the parties…Carrier maintains its position as outlined in the original response."

Response Submitted by: Flahive, Ogden & Latson, P. O. Drawer 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 6, 2009 Through February 11, 2009	Inpatient Hospital Surgical Services	$14,429.07	$14,429.07

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated Undated

- BL — CV — THIS CHARGE WAS REVIEWED THROUGH THE CLINICAL VALIDATION PROGRAM.
- BL — CV — ALLOWANCE IS RECOMMENDED AT FEE SCHEDULE RATE FOR IMPLANT CHARGES THAT ARE SUPPORTED BY THE SUBMITTED DOCUMENTATION.
- BL — ANY REDUCTION IS IN ACCORDANCE WITH THE FOCUS-AETNA WORKERS COMP ACCESS LLC CONTRACT. FOR QUESTIONS REGARDING CONTRACTUAL REDUCTIONS, PLEASE CALL 1-800-37-0594.
- BL — TO AVOID DUPLICATE BILL DENIAL, FOR ALL RECON/ADJUSTMENTS/ADDITIONAL PYMNT REQUESTS, SUBMIT A COPY OF THIS EOR OR CLEAR NOTATION THAT A RECON IS REQUESTED.
- 45 — 45 — CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT.

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. The insurance carrier reduced disputed services with reason codes "45 – CHARGES EXCEED YOUR CONTRACTED/LEGISLATED" and "BL- ANY REDUCTION IS IN ACCORDANCE WITH THE FOCUS-AETNA WORKERS COMP ACCESS LLC CONTRACT." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on March 24, 2010 the Division requested the respondent to provide a copy of the referenced contract. On July 16, 2013 the Division also requested documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the no documentation was provided to support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

   Review of the documentation finds that that the facility requested separate reimbursement for implantables; for that reason, the requirements of subsection (g) apply.

3. §134.404(g) states, in pertinent part, that "(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.
   (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

Review of the documentation found supports that the following items were certified as required by (g):

Itemized Statement Rev Code or Charge Code	Itemized Statement Description	Cost Invoice Description	Implantable Billed Price	# Units & Cost Per Unit	Cost Invoice Amount	***Per item*** Add-on (cost +10% or $1,000 whichever is less).
278	IMP CEMNT FULL DOSE STRYI	SIMPLEX P FULL DOSE	$944.00	2 at $94.40 ea	$188.80	$207.68
278	IMP ENCORE TIBIAL BASEPLT SZ 6	INSERT CONSTRND SZ6	$9,470.00	1 at $2,000.00 ea	$2,000.00	$2,083.40
278	IMP ENCORE TIBIAL INSRT SZ 6	INSERT, CONSTRND SZ 6	$10,000.00	1 at $2,000.00 ea	$2,000.00	$2,200.00
278	IMP ENCORE FEMRL COMP SZ 8 RT	FEMUR, PS-REV NP R, SZ 8	$31,000.00	1 at $6,200.00 ea	$6,200.00	$6,820.00
278	IMP ENCORE PATELLA 38MM	PATELLA, A/P 9MM 38MM	$3,670.00	1 at $735.00 ea	$735.00	$808.50
278	IMP ENCORE TIBIAL INSERT SZ 6	STEM TIB COCR SZ6R	$10,000.00	1 at $2,000.00 ea	$2,000.00	$2,200.00
278	IMP ENCORE FEMRLMODULR STEM	STEM, FEMORAL 100MM-14MM	$6,000	1 at $1,200.00 ea	$1,200.00	$1,320.00

$14,217.80	$15,639.58
Total Supported Cost	**Sum of Per-Item Add-on**

The division finds that the facility supported separate reimbursement for these implantables, and that the cost invoices were certified as required. Therefore, the MAR is calculated according to §134.404(f)(1)(B).

4. §134.404(f)(1)(B) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 108%, ***plus*** reimbursement for items appropriately certified under §134.404(g). Per §134.404(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.404(g). The facility's total billed charges for the separately reimbursed implantable items are $71,089.00. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments. The Medicare IPPS payment rates are found at http://www.cms.gov, and the sum of the per-item add-on for which separate reimbursement was requested are taken from the table above.

- Documentation found supports that the DRG assigned to the services in dispute is DRG 470, and that the services were provided at Pine Creek Medical Center. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $19,896.38. This amount multiplied by 108% results in an allowable of $21,488.09.
- The total cost for implantables from the table above is $14,217.80. The sum of the per-billed-item add-ons does not exceed the $2000 allowed by rule; for that reason, total allowable amount for implantables is $14,217.80 plus 10% ($1,421.78), which equals $15,639.58.

Therefore, the total allowable reimbursement for the services in dispute is $21,488.09 plus $15,639.58, which

equals $37,127.67. Per the submitted explanation of benefits, the respondent issued payment in the amount of $16,078.68. The requestor is asking for an additional $14,429.07 per the submitted DWC-060 form, this amount is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $14,429.07 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Greg Arendt	December , 2013
Signature	Medical Fee Dispute Resolution Officer	Date
	Martha Luevano	
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.